TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Beth Ann Applegate, D.C.

Respondent Name
American Zurich Insurance Company

MFDR Tracking Number
M4-17-1536-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 25, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The following bill was audited and paid incorrectly. TDI-DWC addresses Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations with Rule 134.204, Subsection (k). The Rule states **the reimbursement shall be $500.00 in accordance with subsection (i).**"

Amount in Dispute: $495.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOB(s) and the reduction rationale(s) stated therein. This was a fee schedule adjustment."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 16, 2016	Designated Doctor Examination (99456-W8-RE)	$495.00	$495.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services from March 1, 2008, until September 1, 2016.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

Is Beth Ann Applegate, D.C. entitled to additional reimbursement?

Findings

Beth Ann Applegate, D.C. is seeking an additional reimbursement of $495.00 for a designated doctor examination to determine the injured employee's ability to return to work, represented by procedure code 99456-W8-RE. 28 Texas Administrative Code §134.204(k) states, in relevant part:

> The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE." In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports…

Submitted documentation supports that Dr. Applegate performed a designated doctor examination to determine the injured employee's ability to return to work. Therefore, the reimbursement for this service is $500.00. American Zurich Insurance Company paid $5.00. An additional reimbursement of $495.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $495.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $495.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	March 3, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.